CHAPTER 8
SECTION 5

SIGNATURE REQUIREMENTS

1.0. BENEFICIARY, SPOUSE, PARENT OR GUARDIAN SIGNATURE

To require release of needed information and to protect resources, it is usually necessary to have proper signatures on claims. The contractor shall comply with the state law and with the corporate policy applied for requiring signatures on their private business claims in establishing signature requirements for at-risk TRICARE claims. However, when the private or state signature requirements conflict with federal Privacy Act or freedom of information requirements, the latter shall prevail. The contractor shall comply with the following requirements in processing non-network TRICARE claims for which the signature of the beneficiary, spouse, or parent or guardian of a beneficiary is required unless qualifying for an exception. If additional personal information or release of medical information is required to complete claim processing, the claim shall be returned to the beneficiary for his/her signature, unless the beneficiary is not competent. The procedures below are basic guidelines, but are not mandatory requirements unless so indicated.

2.0. PRIVACY ACT REQUIREMENTS

Any relaxation of signature requirements does not, in any way, relax the confidentiality requirement imposed by the Privacy Act. Checks, Explanations of Benefits (EOBs), responses to inquiries, etc., shall be addressed to the beneficiary or parent or guardian of a beneficiary who is incompetent or under 18 years of age. Under the provisions of the Privacy Act of 1974, neither TMA nor a claims processor shall provide the non-custodial parent with any information concerning the processing of TRICARE claims for the minor children without the written consent of the custodial parent. In the case of divorce or legal separation only the custodial parent shall have access to the medical record(s), unless the divorce or legal separation decree gives rights to the records to the non-custodial parent. Questions regarding custodial parent issues should be addressed to the TMA Office of General Counsel.

3.0. BENEFICIARY IS UNDER 18 YEARS OF AGE

3.1. Non-Participating Provider Claims

Normally, the claim should be signed by the parent or legal guardian if the beneficiary is under 18 years of age. However, if the beneficiary signs the claim form legibly, the claim should be processed unless there is other reason to return the claim form, or doing so conflicts with state law or contractor policy. Request the parent/legal guardian signature, if the claim form is returned except for the two exceptions listed below. In the following situations, a beneficiary under 18 years of age may always sign the claim form in his or her own behalf in accordance with state laws related to the age of consent and the Federal Privacy Act.

3.1.1. Exceptions

3.1.1.1. He or she is (or was) a spouse of an active duty service member or retiree; or

3.1.1.2. The services are related to venereal disease, drug or alcohol abuse, or abortion.

3.2. Participating Provider Claims

If a claim is signed by a beneficiary who is under 18 years of age but the provider agrees to participate, it is not necessary to obtain the signature of the parent/legal guardian.

4.0. BENEFICIARY IS 18 YEARS OF AGE OR OLDER (INCOMPETENT OR INCAPABLE)

4.1. When the beneficiary is mentally incompetent or physically incapable, the person signing should be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. The person signing should:

4.1.1. Write the beneficiary's name in the appropriate space on the claim form, followed with the word "by" and his or her own signature;

4.1.2. Include a statement that a legal guardian has not been appointed, if such is the case; and

4.1.3. Include documentation of appointment if a legal guardian has been appointed or if a power of attorney has been issued. Attach a statement giving his or her full name and address, relationship to the patient, and the reason the patient is unable to sign. Beneficiaries who have no legal guardian or family member available to sign claims, can provide documentation (i.e., a report from a physician describing the physical and or mental incapacitating illness). For those conditions/illnesses which are temporary, the signature waiver needs to specify the inclusive dates of the condition/illness.

4.2. A beneficiary who is physically incapable of signing their signature can have a general or limited power of attorney issued by having their "mark" (e.g., an "X") witnessed and notarized.

5.0. BENEFICIARY DECEASED

5.1. If the provider of care has an approved signature on file agreement and the beneficiary expires, the authorization for payment will satisfy the signature requirements and the contractor shall process the claim.

5.2. If the beneficiary is deceased, the claim form must be signed by the legal representative of the estate. Documentation must accompany the claim form to show that the person signing is the legally appointed representative. If no legal representative has been appointed, the claim form may be signed by the parent, the spouse, or the next of kin. The signer must provide a statement that no legal representative has been appointed. The statement should contain the date of the beneficiary's death and the signer's relationship to the beneficiary to enable the contractor to update the history file.

5.3. In the event that there is no spouse, parent or guardian to sign the claim form for a deceased beneficiary, the claim must be signed by the surviving next of kin or a legally appointed representative (indicate relationship to beneficiary).

5.4. When there is no spouse, parent or guardian to sign the claim form for a deceased beneficiary, no next of kin, and no legal representative, the contractor shall arrange to pay the provider whether network or non-network for services rendered in accord with state law and corporate policy.

6.0. BENEFICIARY SIGNATURE ON FILE

Use of the signature on file procedure is the provider's indication that he or she agrees to the following requirements:

6.1. Verification of the beneficiary's TRICARE eligibility at the time of admission or at the time care or services are provided.

6.2. Incorporation of the language below, or comparable language acceptable to the TRICARE contracts, into the provider's permanent records.

6.2.1. Institutional Providers

> "I request payment of authorized benefits to me or on my behalf for any services furnished me by **(Name of Provider)**, including physician services. I authorize any holder of medical or other information about me to release to **(Contractor's Name)** any information needed to determine these benefits or benefits for related services." Professional providers who submit claims on the basis of an institution's signature on file should include the name of the institutional provider that maintains the signature on file. The UB-92 instructions shall be followed for certifying signature on file except that the permanent hospital record containing a release statement will be recognized. Institutional includes all claims related to an institution.

6.2.2. Professional Providers

> "I request that payment of authorized benefits be made either to me or on my behalf to Dr._____, for any services furnished me by that physician. I authorize any holder of medical information about me to release to **(Contractor's Name)** any information needed to determine these benefits or the benefits payable for related services."

6.3. If a claim is submitted by a nonparticipating provider and payment will not be made to the patient, the provider must indicate the name, address, and relationship of the person to whom payment will be made. This will be the sponsor, other parent or a legal guardian for minor children or incompetent beneficiaries, except for claims involving abortion, venereal disease or drug / alcohol abuse.

6.4. Cooperate with the contractor postpayment audits by supplying copies of the requested signature(s) on file within 21 days of the date of the request and / or allow the

contractor access to the signature files for purposes of verification. See Chapter 1, Section 4, paragraph 4.1. and Chapter 14, Section 4, paragraph 3.0. for audit requirements.

6.5. Correct any deficiencies found by the contractor audit within 60 days of notification of the deficiency of participation in the signature relaxation program will be terminated. Outpatient professional such as physician's office and suppliers such as Durable Medical Equipment (DME). Authorized individual providers have the option to retain on their own forms appropriate beneficiary release of information statements for each visit or obtain and retain in his or her files a one-time payment authorization applicable to any current and future treatment that the physician may furnish him or her. Claim forms must indicate that the signature is on file.

6.6. Institutional Claims

Outpatient hospital, professional inpatient and outpatient hospital services for release of information purposes, the provider must obtain the beneficiary or other authorized signature on a permanent hospital admission record for each separate inpatient admission. A professional provider submitting a claim related to an inpatient admission must indicate the name of the facility maintaining the signature on file. Claim forms must indicate that the signature is on file.

6.7. Professional Provider Claims

Outpatient professional such as physician's office and suppliers such as Durable Medical Equipment (DME). Authorized individual providers have the option to retain on their own forms appropriate beneficiary release of information statements for each visit or obtain and retain in his or her files a one-time payment authorization applicable to any current and future treatment that the physician may furnish him or her. Claim forms must indicate that the signature is on file.

6.8. Outpatient Ancillary Claims

Such as claims that are submitted from an independent laboratory where, ordinarily, no patient contact occurs. A provider submitting a claim for diagnostic tests or test interpretations, or other similar services, is not required to obtain the patient's signature. These providers must indicate on the claim form: "patient not present." For services when there is patient contact, such as services furnished in a medical facility which is visited by the beneficiary, the same procedure used for professional claims for outpatient services is required, except that the provider will indicate along with "signature on file" information, the name of the supplier or other entity rather than a physician maintaining the signature on file.

6.9. Verification Of Provider's Compliance With The Beneficiary Signature On File Requirement

The contractor shall verify beneficiary signature on file compliance using the postpayment audit requirement in Chapter 1, Section 4, paragraph 4.1., and the audit procedures in Chapter 14, Section 4, paragraph 3.0.

7.0. UNACCEPTABLE SIGNATURES

A provider or an employee of an institution providing care to the patient may not sign the claim form on behalf of the beneficiary under any circumstances. Nor can an employee of a contractor execute a claim on behalf of a beneficiary (unless such employee is the beneficiary's parent, legal guardian, or spouse). Beneficiaries who have no legal guardian or family member available to sign claims, can provide documentation (i.e., a report from a physician describing the physical and/or mental incapacitating illness). For those conditions/illnesses which are temporary, the signature waiver needs to specify the inclusive dates of the condition/illness. If the beneficiary is unable to sign due to an incapacitating condition/illness, the provider can annotate in the Signature Box on the TRICARE claim form "Unable to sign." A letter from the provider shall be attached to the claim form describing the physical and or mental incapacitating illness. For those illnesses which are temporary, the letter needs to specify the inclusive dates of the illness.

8.0. BENEFICIARY SIGNATURE WAIVER

8.1. Administrative Tolerance - Certain Ancillary Services

Claims for inpatient anesthesia, laboratory and other diagnostic services in the amount of $50 or less, provided by physician specialists in anesthesiology, radiology, pathology, neurology and cardiology should not be returned for beneficiary signature unless required by state law or contractor corporate policy. Claims submitted by an institution when the claim is for those specific ancillary services cited above, should be included in this tolerance it the services were performed in an institution other than the institution in which the beneficiary is receiving inpatient care.

8.2. Beneficiary (Sponsor, Guardian Or Parent Moved) Unable To Locate

Requirements for a beneficiary's (sponsor, guardian or parent) signature should be waived in the following situations for claims received from non-network participating providers. The contractor should grant a waiver after the procedures described below have proven unsuccessful. If unable to obtain a signature because the beneficiary has moved and left no forwarding address, the contractor shall attempt to obtain the address by telephone or from internal files. The contractor who has on-line access to DEERS screens providing sponsor or beneficiary's addresses may use DEERS. If a new address is obtained, the original claim should be returned to the beneficiary or sponsor with a request for signature. If the claim was submitted by a provider, a **copy**, with the diagnosis and any sensitive information deleted, shall be sent to the beneficiary or sponsor. If the signature is not obtained because the new address is still not valid and the patient cannot otherwise be located, the contractor should grant a signature waiver for a participating provider. Nonparticipating provider claims must be denied. However, if the address is valid, and the contractor knows, through the claim development process, that the beneficiary or sponsor does not wish to file a claim, the claim(s) must be denied whether or not the provider participates.

NOTE: If the contractor obtains a new address, this address cannot be released to the provider.

9.0. PROVIDER SIGNATURE

9.1. Network Provider

Signature requirements for network providers are dependent upon the provisions of the agreement and administrative procedures established between the providers and the contractor.

9.2. Non-Network Provider

The signature of the non-network provider, or an acceptable facsimile, is required on all participating claims. If a non-network participating claim does not contain an acceptable signature, return the claim. The provider's signature is also required to certify services rendered when a provider completes a nonparticipating claim for the beneficiary. If the provider does not sign, the contractor may contact the provider by telephone to verify the delivery of services or return the claim for signature. A claimant may also attach an itemized bill on the letterhead / billhead of the provider verifying delivery of services.

9.3. Facsimile Or Representative Signature Authorization

In lieu of a provider's actual signature on a TRICARE claim, a facsimile signature or signature of a representative should be accepted if the contractor has on file a notarized authorization from the provider for use of a facsimile signature (Chapter 8, Addendum A, Figure 8-A-6) or a notarized authorization or power of attorney for another person to sign on his or her behalf (Chapter 8, Addendum A, Figure 8-A-7). The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim form is computer-generated. The authorized representative may sign using the provider's name followed by the representative's initials or using the representative's own signature followed by "POA" (Power of Attorney), or similar indication of the type of authorization granted by the provider.

9.4. Verification Of Provider Signature Authorization

In the absence of any indication to the contrary, contractors should assume the proper authorization is on file, validating through file checks, those claims containing facsimile and representatives' signatures which are included in their quality control audit, and program integrity samples. The contractor should remind providers of the requirement for current signature authorizations through at least annual notice in routine bulletins or newsletters and at other appropriate times when contacts are made. The contractor may return a claim with a request for the signature authorization when it is found that there is no authorization on file or it is out-of-date:

9.4.1. Send a request to the provider advising of the need for authorization and;

9.4.2. Set a utilization flag on the provider's file to stop further payment to the provider when the proper signature is not on the claim, pending receipt of the authorization.

9.4.3. Advise the provider that if the authorization is not received, it will be necessary to deny the claim or to process it as a nonparticipating claim, depending on the information available to make a payment determination.

9.4.4. Schedule a contractor representative visit to resolve any problem which may develop in the unlikely event a provider chooses not to cooperate.

9.5. Certification Of Source Of Care

Source of care certification is used to help determine the correct payee on the participating UB-92 and the HCFA 1500. If signed by the provider and the certification is unaltered, issue payment to that provider. If signed with alteration of the certification, issue payment to the beneficiary (parent/legal guardian of minor or incompetent). If unsigned and an itemized billing on the provider's letterhead is not attached, return the claim.

NOTE: For procedures in case of any irregularities, refer to Chapter 14, Program Integrity.